

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5429PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREATER VEGAS PERSONAL CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4905 ALTA DR LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 10/19/09 and finalized on 11/06/09, in accordance with Nevada Administrative Code, Chapter 449, Personal Care Agencies.</p> <p>Complaint #NV00023018 was substantiated with deficiencies cited.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following regulatory deficiencies were identified.</p>	P 000		
P 080	<p>Section 14.1(4) Administrator Responsibility Abuse/Neglect</p> <p>4. The administrator of an agency shall ensure that: (a) The clients of the agency are not abused, neglected or exploited by an attendant or another member of the staff of the agency, or by any person who is visiting the client when an attendant or another member of the staff of the agency is present; and (b) Suspected cases of abuse, neglect or exploitation of a client are reported in the manner prescribed in NRS 200.5093 and 632.472.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the</p>	P 080		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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P 080	<p>Continued From page 1</p> <p>agency failed to report a suspected case of abuse, neglect or exploitation of a client to the Department of Aging and Disability Services as required by statute.</p> <p>1. Review of Client #1's record revealed no report was filed for the suspected neglect with regard to Client #1.</p> <p>2. Interview with the supervisor of the office revealed that she did not report the neglect and also did not know that she was a mandatory reported. She relayed that she instructed the personal care attendant to report the situation to the mobile home park manager. The Manager of the mobile home park was interviewed and she confirmed that she reported the neglect.</p> <p>Scope: 1 Severity: 2</p>	P 080			

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